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ABSTRACT

This document contains chapter 1 (8 articles) from a collection of 35 articles primarily from American Association for Counseling and Development (AACD) publications on the most important legal and ethical topics about which all school counselors need to be informed. "Ethical Standards for School Counselors: Test Your Knowledge" (Wayne C. Huey) and "The Role of a Code of Ethical Standards in Counseling" (Alan R. Mabe and Stephen A. Rollin) explain the importance of knowing the contents of professional codes of conduct and the purposes and limitations of such codes. "The Child's Rights: Whose Responsibility?" (Patricia A. Ferris and Malcolm E. Linville) explores the school counselor's responsibility to respect and protect the rights of minors. "Adolescents' Rights of Access to Counseling" (John R. Klenowski) examines the question of whether adolescents have a right to seek or refuse counseling services. "Avoiding Ethical Violations: A Timeline Perspective for Individual Counseling" (Mary E. DePauw) discusses ethical issues in the counseling relationship. "When a Colleague Practices Unethically: Guidelines for Intervention" (James L. Levenson) discusses how a school counselor should address conduct by a colleague that could cause harm to clients. "Reporting Unethical Practices: Revised Guidelines" (William Marchant) responds to the suggestions offered by Levenson in the previous article. "Ethical Concerns in School Counseling" (Wayne C. Huey) presents a common ethical dilemma confronting high school counselors. (NB)

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ETHICAL STANDARDS

The importance of knowing the contents of professional codes of conduct and the purposes and limitations of such codes is explained in the first two articles in this chapter. Huey (1987) presents a quiz to help school counselors assess their current levels of awareness and understanding of their ethical standards. Although detailed memorization of the ethical codes is not required, school counselors should have at least a basic understanding of their ethical responsibilities as defined in these documents.

Mabe and Rollin (1986) discuss the purposes of ethical codes and their limitations. The ethical standards of ASCA and AACD present school counselors with the behaviors to which they should aspire and give general guidelines for addressing difficult issues. They do not, however, necessarily provide answers to the many specific dilemmas that practitioners will face. When the standards do not provide enough direction, counselors are encouraged to consult with colleagues, professional experts, and perhaps their administrative supervisors before taking action.

Ferris and Linville (1985) explore the school counselor's responsibility to respect and protect the rights of minors. In many instances, school counselors must serve as parental substitutes in a child's life. As the more powerful party in the relationship, school counselors must be careful to respect the privacy of students and at the same time take any necessary steps to protect them from harm.

The difficult question of whether adolescents have a right to seek or refuse counseling services is explored by Klenowski (1983). Legally, counselors are responsible to the parents or guardians for

the care of any minors they counsel. Parents have the right to initiate or terminate counseling relationships for their children. As a result, school counselors need to understand the rights of parents and include them in the counseling process to the degree appropriate in each case.

A discussion of ethical issues from the inception of the counseling relationship through its termination is offered by DePauw (1986). School counselors need to be aware of their ethical responsibilities early in the counseling relationship, particularly regarding informed consent, and they need to watch for other issues in subsequent stages.

Almost all professionals, at some point in their career, suspect or become aware of a colleague's unethical behavior. School counselors are obligated to address any conduct by a colleague that could cause harm to clients. Counselors should: (a) try to resolve the issue by confronting the colleague directly, if possible; (b) report the behavior to a superior, professional association, or credentialing authority if a direct confrontation is not possible or is not effective; and (c) take steps to protect any vulnerable clients. Levenson (1986) discusses some of the problems with this process and Marchant (1987) responds to his suggestions.

Huey (1986) presents a common ethical dilemma confronting high school counselors and reminds them that they will always be called upon to exercise good judgment no matter how explicit ethical standards might seem.

Ethical Standards for School Counselors: Test Your Knowledge

Wayne C. Huey

School counselors have expressed varying degrees of dissatisfaction with the perceived adequacy of the *Ethical Standards* (1981) of the American Association for Counseling and Development (AACD) and their applicability to counseling children and youth (Wagner, 1981). In 1983, the American School Counselor Association (ASCA) acknowledged the need for a code of ethics that specifically addressed ethical issues confronting school counselors. The *Ethical Standards for School Counselors* (1984) were not intended to replace the AACD *Ethical Standards* but were "developed to complement the AACD standards by clarifying the nature of ethical responsibilities of counselors in the school setting" (ASCA, 1984, p. 1).

Counselors can test their knowledge of the ASCA *Ethical Standards for School Counselors* by responding to the cases described in the following test and then studying the standards that are keyed by section and item number to each test situation. Moreover, counselors can increase their levels of awareness and understanding of the standards and thus become more competent and comfortable in making ethical decisions.

The ASCA standards address counselor responsibilities to pupils, parents, colleagues and professional associates, school and community, self, and the profession. Conflicts among these responsibilities are inevitable, because ethical standards are general guidelines for professional behavior, not laws, and must be interpreted by each counselor in each context. Factors affecting the interpretation of ethical standards include the counselor's personal needs, values, beliefs, and attitudes.

Experienced school counselors know that it is not always easy to interpret ethical standards; however, counselors can enhance this process by engaging in an honest self-examination, keeping

abreast of current issues by reading professional journals, participating in continuing education activities, and consulting with professional colleagues (Corey, Corey, & Callanan, 1984). Even with these resources, situations will continue to arise for which there are no obvious answers. Counselors will have to struggle with themselves to find the best way to assist their clients. The positive side of the struggle is that it allows counselors the freedom to exercise their good judgment within the general framework of the ethical standards.

The following test is similar in format to Bailey's (1980) ethics test. Counselors are encouraged to complete both assessments as part of a self-examination.

Ethical Standards for School Counselors: Test Your Knowledge

Each of the following cases has been selected to stimulate your thinking about specific ethical standards. In each situation, determine whether you *agree* (A) or *disagree* (D) with the counselor's decision and place the appropriate letter (A or D) in the blank. For each dilemma, a citation to the American School Counselor Association (ASCA) *Ethical Standards for School Counselors* (1984) is provided.

_____1. The principal of an affluent suburban high school was under community pressure to ensure that the majority of graduates enrolled in college. As a result of this pressure, the counselors were instructed to "do a little arm twisting" with any students who were reluctant to apply to college. The counselors agreed to cooperate because they also believed that a college education was a worthy goal for everyone. (Preamble, Items 2 and 3; Section A-1)

_____2. A 16-year-old girl reported that she was pregnant and wanted a referral to an abortion clinic. The counselor suggested that the teenager discuss the situation with her parents before making a decision and offered to provide assistance if the girl chose to follow the recommendation. (B-1)

_____3. A counselor learned that several students had obtained copies of a final examination for an English class. The situation was reported to the English teacher without revealing the students' names. (D-2)

_____4. A counselor noticed that the secretary frequently left student records in full view on top of the desk when she was

out of the office. Students had been observed looking at the records. The counselor decided to remind the secretary of the confidentiality guidelines, even though she had ignored previous reminders and had resented the counselor's suggestions. (C-2)

_____5. A counselor with a strong aversion to homosexuality was confronted by a gay student who confessed to a physical attraction to the counselor. The counselor attempted to conceal personal feelings and decided to try and counsel the student toward a heterosexual orientation. (E-3, A-4)

_____6. Based on information provided by a second-grade student, an elementary school counselor reported a case of suspected child abuse, even though no physical signs of abuse were evident on the child. It turned out that the child had made up the whole story, and the parents were furious with the counselor because they had not been contacted before the report was filed. The counselor still believed that the correct procedure was followed. (A-5, F-4)

_____7. Parents with strict fundamentalist religious beliefs asked the counselor to help them get their daughter "right with God" so that she would stop getting into trouble at school. The counselor, who held very liberal religious beliefs, did not believe that an objective perspective could be maintained and therefore referred the parents to another counselor whose beliefs were more closely aligned with those of the parents. (A-6, E.2)

_____8. A counselor attempted to get professional colleagues involved in the state counseling association. They informed the counselor that they already had too many obligations and did not need the affiliation. The counselor told them that professional involvement was an ethical responsibility. (F-3)

_____9. A student was discouraged by low mathematics scores on the Scholastic Aptitude Test (SAT). In an effort to boost the student's morale, the counselor named several former students who had also scored low on the mathematics section but were currently performing well in college. (A-7)

_____10. An assistant principal for discipline demanded that the counselor conduct a group for disruptive students to "straighten them out." The students were to be required to attend under threat of suspension. Unable to change the assistant principal's mind, the counselor made an appointment with the principal to explain why leading a group under those conditions would not be appropriate. (D-3)

_____11. A counselor attended a workshop on hypnosis and excitedly returned to school to use the newly learned techniques

in helping students cope with test anxiety. When questioned by a colleague, the counselor insisted that the benefits would far outweigh any possible risks. (E-1)

_____12. The 15-year-old daughter of a counselor's close friend confided that she was sexually involved with her boyfriend and wanted to know where to obtain contraceptive information. The counselor provided the referral information and then informed the girl's mother of her activities. (A-8)

_____13. A young boy's parents expressed their concerns about his effeminate appearance and behavior. They asked for the counselor's assistance in determining whether their son was a homosexual. In interviewing the client, the counselor told him that his parents were afraid that he was gay. (B-4)

_____14. Upon receipt of Preliminary Scholastic Aptitude Test scores, the counseling department chairperson suggested that a meeting be scheduled with students to interpret test results. A colleague believed that such a meeting was unnecessary because an interpretive booklet was provided for each student with the score report. The department chairperson insisted that an interpretive session would be more beneficial. (A-10)

_____15. A counselor repeatedly turned down opportunities to attend professional conferences. The counselor stated that being away from school was a waste of valuable time and that extensive graduate training had provided more than adequate preparation for the job. (E-4)

_____16. A male counselor held daily counseling sessions behind closed doors with an attractive female student. To save the reputation of the counseling department, a colleague reported to the principal that "something is going on in there." (C-3)

_____17. The counselor informed a senior that he would not graduate because of a failing grade in his English class. The angry student, who had a history of violent behavior, threatened to kill the English teacher. The counselor told the student that the teacher, an administrator, and the student's parents must be informed of the threat. (A-9)

_____18. A counselor routinely encouraged students to be liberal free thinkers and not to conform to the dictates of parents and society. Using personal experiences for references, the counselor encouraged students to explore all of life, including experimentation with drugs and sex, if they so desired. (A-4)

_____19. A counselor used reality therapy in working with students who had attendance problems. When the principal asked

for some evidence of the program's effectiveness, the counselor stated that there was not enough time to do an evaluation. The counselor then told the principal where to go for information on reality therapy's effectiveness. (F-2, D-4, C-1)

_____20. A counselor solicited students for a leadership training group. After the second session, the counselor noted that six of the eight group members were having severe family problems because their parents were either divorced, separated, or thinking about getting a divorce. Without announcing a change, the counselor shifted the focus of the group to address the more immediate needs of the students. (A-3)

_____21. Believing that humor would ease student anxiety during administration of the SAT, a counselor developed and used several jokes pertinent to testing and college admissions. The counselor carefully worked the jokes into the reading of the standardized test directions, and the students seemed to appreciate the attempt to humanize the test administration. (A-11)

_____22. Although local school guidelines prohibited long-term family counseling, the counselor continued to provide these services for families in need. The counselor stated that the local mental health center was understaffed and that the mental health counselors were not trained any better than the school counselor. (B-6)

_____23. A counselor worked with members of the school track team in an effort to improve athletic performance. Several colleagues criticized the use of the counselor's time, citing the need for more academically oriented programs. The counselor believed that this program was an appropriate service for the student athletes. (A-2)

_____24. An elementary school student was referred to a mental health clinic because of severe emotional problems. Although the student resisted the change in counselors, the parents supported the referral. The student demanded that the school counselor not reveal anything they had discussed. Because the counselor had discussed the possible need for consultation before working with the student and because the parents supported the referral, the counselor felt comfortable in disclosing complete client data to the mental health agency counselor. (C-4)

_____25. A counselor repeatedly observed a colleague violating an ethical standard in working with students. Concerned about harmful effects on the students, the counselor filed a report with the ASCA Ethics Committee. (G-1, G-2)

Suggested Responses

Agree (A): 2, 3, 4, 6, 7, 8, 10, 14, 17, 23, 24

Disagree (D): 1, 5, 9, 11, 12, 13, 15, 16, 18, 19, 20, 21, 22, 25

Score Interpretation By Number of Correct Answers

24–25: Apply for a position on the ASCA Ethics Committee.
21–23: An experienced, well-educated, ethical counselor.
20: Passing score. Consult with colleagues on questionable cases.
18–19: Attend programs and workshops on ethical issues and read professional counseling journals.
15–17: Explore your values in relation to those of more ethical school counselors.
13–14: Obtain and read the *Ethical Standards for School Counselors*.
12 and below: Ask your counselor educator to read and explain the Ethical Standards for School Counselors to you.

The author will respond to written inquiries about the interpretation of any of these cases for 6 months after date of publication. Readers should refer to the ASCA *Ethical Standards for School Counselors* (1984) before requesting an interpretation. The ASCA standards may be obtained by writing ASCA Headquarters, 5999 Stevenson Avenue, Alexandria, VA 22304. For additional case studies with more detailed interpretations, counselors are referred to Corey et al. (1984), Callis, Pope, and DePauw (1982), and Stude and Goodyear (1975).

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The Role of a Code of Ethical Standards in Counseling

Alan R. Mabe and *Stephen A. Rollin*

The authors focus on the role of a code of professional ethics as a basis for articulating the responsibilities of a member of a profession. Although concentrating on the AACD Ethical Standards, *they attempt to provide some of the lessons learned in other professions, particularly medicine, regarding the role of the code and the problems and limitations involved in constructing and using a code of ethics.*

Counseling practitioners, researchers, and educators are well aware of the need to address ethical questions that arise in their work. One way of addressing this need is through a code of professional ethics. A revised document on ethical standards (American Association for Counseling and Development, 1981) was approved by the Executive Committee of the American Personnel and Guidance Association.

Medicine has been the focus of contemporary debate regarding what the content of an ethical code should be, who should decide that content, and what role the code should have in the profession and in society (Beauchamp & Childress, 1983). Given the unrest and the problems encountered in the area of medical ethics and the changing content and role of medical codes, it is important to examine carefully the advantages and difficulties that will be encountered by the practitioner in using the counseling code. In this article we discuss the importance of having a set of standards and the problems and limitations in a code of professional ethics.

The kinds of codes under discussion are codes of professional ethics. The primary types of items to be found in a code are (a) the specific duties or rights that differ from ordinary ethical requirements, (b) the specific duties or rights that may simply be the application of general ethical principles in a particular professional area, (c) a reiteration of certain ordinary ethical requirements that

need emphasis for some reason, (d) aims or general goals that the profession should aspire to realize, (e) requirements that relate to coordinating or protecting the interest of members of the profession, and (f) a statement of the responsibility of members of the profession for reporting code violations or other violations. Items (a), (c), and (f), in particular, make a code necessary for the profession.

Although its primary function is to establish a framework for professional behavior and responsibility, the code also serves as a vehicle for professional identity and a mark of the maturity of the profession. A responsible member of the counseling profession must look to various sources for guidance. We fear that many professions may see a code of ethics as the sole basis for explicating responsibility for its members. The code is clearly a central part, but only a part, of the basis for the explication of professional responsibility. A professional code is necessary but not sufficient for the exercise of professional responsibility. An awareness of a code's limitations is a key element in developing an adequate account of professional responsibility. A proper appreciation of the strengths and limits of codes is directly related to the wise use by the profession of its autonomy.

In the discussion and practice of medical ethics in the past 25 years, there has been a dramatic shift from a paternal model of physician-patient relations to what many refer to as a "rights" model of that relationship. The movement has been from a situation in which physicians had virtually complete autonomy to set the standards for their behavior and interaction with patients to a situation in which their behavior is significantly circumscribed by patients, courts, regulatory agencies, and institutional lay boards (Beauchamp & Childress, 1983). In the process, practitioners' autonomy to set the standards for their profession was attacked and to a significant degree lessened. There are many complex factors that account for this development; however, here we can only identify the general structure of what happened. A profession renders a service to society, and traditionally society has been willing to grant a large degree of autonomy to that profession to set the terms and ethical standards for its activities (Bayles, 1981). A profession can use that grant of autonomy well or poorly. If the public judges that a profession does not use its autonomy well, it will withdraw the grant of autonomy and become an active participant in setting standards for that profession's services.

If the profession's autonomy is to be used wisely, then there must be a careful and critical scrutiny of the strengths and limi-

tations of the use of a code of ethics. We will concentrate on selected problems and limitations in the use of a code, not because there are not strong arguments for a code but because we want to articulate the pitfalls based in part on the experience of the use of codes of ethics in other professions. We have selected the following six issues that constitute either problems or limitations in the use of a code to explicate professional responsibility:

1. There are some issues that cannot be handled in the context of a code.
2. There are some difficulties with enforcing the code, or at least the public may believe that enforcement committees are not tough enough on their peers.
3. There is often no way to systematically bring the interests of the client, patient, or research participant into the code construction process.
4. There are parallel forums in which the issues in the code may be addressed with the results sometimes at odds with the findings of the code (e.g., in the courts).
5. There are possible conflicts associated with codes: between two codes, between the practitioner's values and code requirements, between the code and ordinary morality, between the code and institutional practice, and between requirements within a single code.
6. There is a limited range of topics covered in the code, and because a code approach is usually reactive to issues already developed elsewhere, the requirement of consensus prevents the code from addressing new issues and problems at the "cutting edge."

Issues That Cannot Be Handled in the Code Context

One issue that cannot be handled in the context of the code is the conflict between autonomy and welfare. This issue is at the core of competing moral and political conceptions, and although a code may make reference to these ideas, it cannot provide a definitive result. An emphasis on autonomy stresses self-direction and the rights of the individual, an emphasis on welfare stresses satisfaction or benefit over self-direction. In Section B.1 of the AACD (1981) *Ethical Standards*, a member's primary obligations are identified: "to respect the integrity and promote the welfare of the client(s) . . ." (1981). Integrity is closely related to autom-

omy. What is one to do if there is a conflict between the welfare of a person and the autonomy of a person? This is a difficult question that is not susceptible to a "code" solution. The issue of the conflict between welfare and autonomy is at the core of the disputes between utilitarians and Kantians in applied and technical ethical discussions. It is difficult to articulate a code without invoking ideas or concepts that are significantly contested in moral, political, or legal thought. These issues cannot be settled by fiat, so a code is always at the mercy of the continuing debate in other domains.

Problems With Enforcement

Defensible and enforcible standards are important in the exercising of autonomy. There is always the possibility that the public or members of the profession will attach different degrees of seriousness to violations of the code or to behavior judged to be unacceptable in other ways. It is highly likely that the public's perception that medical societies were not willing to punish their own members to the degree the public thought justified led to the attack on the autonomy of the medical profession. The code must communicate to the public that it is more than just a paper document, that it is enforced, and that members who violate the code are disciplined. Currently AACD does not have a provision for publication of the names of those who are disciplined for violating the standards of the professional code. In contrast, the American Psychological Association (APA) provides a list to its members of those who have been disciplined along with a notation of the specific area of the code that has been violated. There are two problems: (a) whether sufficient penalities are imposed for violations, and (b) whether the public perceives that the profession is really regulating itself. A profession must successfully deal with both problems or the code and the profession will come under attack by the public through its various institutions.

Interest of Clients

Although there are several issues involved in a code, practitioner-client interaction is at the core of any code. The professional code gives the members of that profession the right to set the standards for interacting with clients. It is natural to wonder how

the interests and rights of clients are to enter the code construction process. In counseling, people are oriented toward helping others, so one may presume there is a basic regard for the interest of clients and patients. One could argue that those responsible for the construction and administration of the code will have the best interests of patients in mind in their work (and there is no reason to doubt that they do), but clients do not have an opportunity to represent their interests directly in a process in which they have any degree of control. The paternal medical model, which operated under the rationale of benefiting the patient, came under severe attack by individuals and organized consumer groups for not giving due regard to the needs and rights of patients. To maintain autonomy of the profession, ethical standards must function to protect clients. The nature of an autonomous code approach is to have a profession regulate itself without client participation in the regulatory process. The problem here is the risk of seriously misrepresenting the interests, needs, or rights of clients. The profession could attempt to systematically bring the point of view of clients and research participants into the process by some type of lay participation or by more effective ways of anticipating how patients and clients understand their interests and rights.

Parallel Forums

There are problems and limitations in the code approach because there are alternative forums in which applicable standards may be set. Later in the article we discuss the problem of conflicting code requirements for those who may be members of more than one professional association. One might argue that because of similar professional tasks and problems the developments are likely to closely parallel each other. But there are other forums in which this is not as likely to be the case—the courts and state and federal regulatory agencies. One formal way to approach this problem is to include a code requirement to obey the law. The problem, however, particularly with court cases in which clients or third parties have a forum for equal participation, is that outcomes rather different than those anticipated in the code may occur. *Tarasoff v. Regents of the University of California* provides an illustration of this point (Applebaum, 1981). In this milestone case the question was raised of whether counselors have a duty to warn third parties against whom their clients have made threats during sessions that

are expected to be held in confidence. The courts ruled there was such a duty to warn. The code is silent on the issue of a duty to warn. The formal requirement to obey the law does not provide a sufficient basis for reconciling the issue of confidentiality as expressed in the code and the developments in the Tarasoff case. As the Tarasoff case shows, codes cannot be definitive even when they speak precisely about a topic, because a parallel but overriding legal forum may arrive at a different position. Codes cannot preclude this from happening, so those bound by a code must be alert to the possibility of other forums reaching conclusions different from the code requirements.

Those other forums are not immune from advice and influence from professional associations. If the professional code reflects a well-conceived position on a particular issue, the profession may be successful in influencing the outcome in parallel forums.

Conflicting Codes

There are numerous kinds of conflicts that may be experienced by a member of a profession governed by a code. Many members of AACD may also belong to APA, the American Association for Marriage and Family Therapists (AAMFT), or the American Association of Sex Educators, Counselors, and Therapists (AASECT), just to name a few. If one receives different guidance from different codes, what is one to do? An example can be found in the section on assessment and testing in the respective codes of AACD and APA. The AACD (1981) *Ethical Standards* have references in Section C to the codes of APA, the Association for Measurement and Evaluation in Counseling and Development (AMECD, formerly AMEG), and the National Council on Measurement in Education (NCME) and to an article, "Responsibilities of Users of Standardized Tests" (APGA, 1978). On the other hand, the APA code has six paragraphs dealing with assessment that are much more general and therefore seem to offer more latitude to the APA members in use of tests. What if this more general statement is at odds with the more specific view of the AACD Code? Which is to be followed? Who should decide this?

A practitioner may have code requirements that conflict with personal or moral values. An obvious example is the issue of abortion. Section B.1 of the AACD (1981) *Ethical Standards* states, "The member's *primary* obligation is to . . . the welfare of the

client." What should happen when a counselor's religious preferences or moral position lead to a view that abortion is wrong, yet from the client's perspective it is in her best interest to have an abortion? Does the counselor state his or her position, disqualify himself or herself, argue against abortion, or give advice based on the values of the client? Can the counselor, if he or she holds a strong belief against abortion, operate ethically and in the best interest of the client without stating his or her position?

Although the very point of a code of responsibility is to establish a set of standards that may be different from the requirements of ordinary morality, in cases in which there are differences between the code and ordinary morality, practioners may experience conflicts. Ordinarily, one should warn another person if one has reason to believe that someone is about to harm that person, but the code requirement of confidentiality seems to override this concern. Obviously, as the Tarasoff case illustrates, there are good arguments for both duties. Although the code addresses conflicts between institutional practices and the code, this remains a troublesome area. Also, as our discussion of integrity and welfare above indicated, there can be conflicting ideas or requirements within a single code.

Finally, there can be situations of conflict that involve more than one of the above examples in a specific situation, making the resolution even more complicated. Of course, conflicts are a part of life and one must be careful not to attribute all these problems solely to the code. After all, there are deep conflicts within and among different approaches to ethical theory. Some of the conflicts within a code simply represent conflicts in the broader culture. Our view is that one must be aware of the problems that remain even when a code is in place and that some of the problems are a function of the use of a code.

Limited Range

A code is a finite document that can cover only a limited number of issues. To some extent historical factors influence the selection of the content of a code. If particular issues are pressing at the time that a code is being constructed, then those issues are likely to be given more attention in the code. There can be oversights and omissions even of important issues. Significant changes in society can result in a code being out of step with the social

consensus. These matters can be addressed by revision committees that meet periodically to bring the code up to date. Many problems of omission or emphasis can be remedied over time. There are, however, some problems that cannot be resolved so easily.

First, the issue of generality versus specificity is a persistent one. If the statement is too general, little actual guidance is provided; if the statements are too specific, the rationales for the specific conclusions may be missing and some issues may be omitted through oversight. Codes attempt to solve this conflict in a variety of ways, most successfully perhaps by a statement of general principles combined with more specific statements of application and supplemental case studies to illustrate the application of principles to specific cases.

Second, for the most part a code must gain wide acceptance in the profession so that it represents the distilled wisdom about which there is a consensus in the profession. It is difficult for a code to be in the forefront of solving issues at the "cutting edge." For example, how should the code respond to issues such as the developments in information technology? More particularly, what impact will new systems for storage and retrieval of information have on the issue of confidentiality? Each specific issue can be worked out over time, but there will always be new issues for which the code is without a response.

Third, many new problems find their earliest resolution in the courts. As our discussion above of parallel forums indicated, there will frequently be court decisions to which the code must react.

Finally, the code, by its nature, is a limited document set in the context of a broader ethical tradition. A code is not meant to cut itself off from that tradition but to carry the values of that tradition into a specialized area. Thus, a code is limited in the sense that it cannot replicate the tradition out of which it grows. That is not a deficiency, but it must be recognized or else there will be a tendency to place too much weight on the code as opposed to the broader ethical traditions and ethical debates out of which the code arises.

The broader ethical tradition can provide considerable insight to constructing and operating a code. There are not precise and agreed upon definitions even of key terms in ethical theory, but there are two distinct and different components of an ethical theory. There is a theory of value and a theory of morality. In a theory of value there is an attempt to identify what is valuable in some fundamental sense (e.g., in the nature of things, for humankind, for one society or tradition, for an individual). In a theory of morality

there is an attempt to establish principles for how people are to treat one another. A social morality will have a set of principled limitations on how people can treat one another. Certain things are simply ruled out, such as murder, rape, coercion, and serious deceit. A code may be more successful in identifying clearly unacceptable behavior in terms of practitioner-client interactions. It is somewhat more difficult to articulate values that should be promoted. In general, rooting code construction in the broader ethical traditions out of which they arise is likely to be beneficial to both the code and the tradition. The broader tradition of ethical theory provides a background out of which many of the ideas in the code have arisen. Awareness of this background is very helpful in interpreting and understanding the code. If the code is silent on an issue or if significant conflicts exist between the code and other directives, the broader ethical tradition can provide a source of guidance and a basis for evaluating practice. And probably most important of all, broader ethical principles can be a source for approaching new problems that are not yet familiar enough for inclusion in the code.

The various problems and limitations of codes can be mitigated to some extent, as we have suggested throughout this article. The solution to the basic problem articulated here—the possibility of overreliance on a code of professional ethics for explicating professional responsibility—is greater understanding of the role and function of a code of ethics in relation to the broader tradition of ethical theory and practice. For example, greater understanding of the debate between Kantians and utilitarians will make theorists and practioners better able to solve conflicts between autonomy and welfare within the code (Frankena, 1973; Kant, 1964; Mill, 1979). Counselors are not alone—being an ethical professional is not independent of being an ethical person.

Our view is that a code of ethical standards is necessary, but, as we have tried to articulate above, there are many problems and limitations to constructing and following a code. These problems also arise in the educational process when the code approach is communicated to students. A full understanding of the code requires an understanding of the strengths, limitations, problems, and functional context of the code. People all strive to be responsible members of their professions. To be a fully responsible professional, one must rely on more than a code of ethical standards in resolving difficulties. Our discussion of the limitations of professional codes has demonstrated that.

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The Child's Rights: Whose Responsibility?

Patricia A. Ferris and *Malcolm E. Linville*

An elementary or middle school counselor might look at the theme of this special issue and ask: "Why another discussion of ethics? I am familiar with the *Ethical Standards* of the American Association for Counseling and Development (AACD, formerly American Personnel and Guidance Association [APGA]) (APGA, 1981), and the *Position Statements* of the American School Counselor Association (ASCA) (1983). I have seen a copy of *Ethical Standards for School Counselors*, also from ASCA (1984). In addition, I have on my desk a copy of the educational amendments made in 1974 to PL 92-380, the Elementary and Secondary Education Act of 1965. These documents provide a firm basis for ethical conduct on the part of the counselor. So why go over established positions again?"

This seems to be a legitimate question, especially with recent articles by Zingaro (1983) and Wanger (1981) that offer interpretations of these basic guidelines. So why not file away another discussion of these subjects?

There are several good reasons not to file this issue. One reason involves a changing conception of the primary role of the counselor that may profoundly affect the functions and responsibilities of elementary and middle school counselors. If the counselor's role changes, as some people predict, then many of our present ethical guidelines become obsolete.

Ethics and Changing Roles of Counselors

The changing roles of counselors are clearly reflected in a recent survey of perceptions of what a counselor should be doing.

Based on a questionnaire sent to principals and counselors in upper elementary and middle schools, both principals and counselors believed that individual counseling should receive the greatest emphasis in a counseling program (Bonebrake & Borgers, 1984). Although the researchers who conducted the survey classified this top-priority activity as a counseling function, the next three functions ranked by counselors apparently were not in the category of counseling. They were what the authors classified as *consultation* functions (teacher consultant, student assessment consultant, parent consultant). Ranks given by counselors were similar to those given by principals. It is significant that a major counseling function, group counseling, was ranked in the middle of the list by both groups.

You might say, "But counselors are expected to talk to teachers and parents, and they have always done this." Indeed, they have, but the term *consultant* is beginning to have more specific meaning in the counseling field. Umansky and Holloway (1984) stated: "Traditionally, counseling services have concentrated on direct service to the individual student . . . Student administrators have been largely unimpressed with the 'individual-adjustment' treatment model because of the high cost per service ratio and its lack of accountability to the school community" (p. 329). The authors concluded bluntly: "Unfortunately, most counselors have failed to adopt the consultant role as their main function in the schools" (p. 330).

The Consultant Role

The consultant role, as it is now defined, removes the counselor from his or her therapeutic role with the student. Rather, in one possible model, the counselor interviews a student who is having difficulties and then prescribes techniques for intervention to be carried out by teachers or parents. The counselor may have little or no direct contact with the student after the initial interview.

A less rigidly defined form of consultation has always been part of the counselor's role but was rarely seen as the counselor's primary function. Yet, a formal change in the role of counselors would raise certain ethical questions that have rarely been addressed.

The present ethical guidelines, from whatever source, are largely based on the assumption that the counselor's primary function is to establish a therapeutic relationship. This is expressed in the ASCA *Position Statements* (1983) as a relationship that "requires

an atmosphere of trust and confidence between the client and the counselor" (p. 6).

In the ASCA *Statements*, the definition of consultation differs greatly from current usage. ASCA's definition is: "The counselor reserves the right to consult with other professionally competent persons when this is in the interest of the client. Confidentiality assures that disclosures made will not be divulged to others except when authorized by the client" (p. 6).

How relevant are these guidelines if elementary counselors begin to see consultation with teachers and parents as a major function involving little direct contact with children? The guidelines are based on the establishment of a close and continuing relationship with a student that emphasizes the student's welfare as the counselor's primary consideration. How can the counselor take responsibility for a student's welfare if he or she is working only indirectly with the student, literally one person removed from the student? How can confidentiality be preserved in such a setting? What are the ethical implications of giving major responsibility for intervention and treatment to an individual who is not professionally trained as a counselor?

The various ethical standards clearly state that counselors have the right to consult with other professionally competent persons when it is in the best interest of the client. Because teachers and parents may not have received such counseling training, they can seldom be considered professionally competent as defined in the standards. Yet the word *consultation*, as used in some of the newer models of counseling, seems to assume parents and teachers are as professionally competent in specific helping techniques as counselors with master's degrees in the field.

In practice, of course, most elementary counselors define consultation much less formally. The counselor has direct contact with the child and also works with the teacher or with the parent when this is desirable. Such consultation involves talking over the situation with the teacher or parent and considering positive solutions together. Yet, even these limited forms of consultation may lead to ethical dilemmas. In the *Position Statements* (ASCA, 1983) it is clearly asserted:

> A client has the right to privacy—and to expect confidentiality. . . . Confidentiality assures that disclosures made will not be divulged to others except when authorized by the client. . . . The main purpose of privileged communication is to offer counselees a relationship in

> which they will be able to deal with what concerns them without fear of disclosures. . . . In reality, it is the client who is privileged. It is the client's own information and the client has the right to say who shall have access to it and who shall not. (p. 6)

Confidentiality in Practice

Suppose the elementary school counselor is working with a child such as Aletha Lindstrom described in the real-life account, "Billy, I Won't Forget You" (1983). Billy came from an unstable home and other children avoided him. If anything was missing in the classroom, they immediately accused Billy of taking it. One day a child could not find her dime and insisted that Billy had stolen it. The teacher lost control of herself and ordered Billy to give back the dime. When he didn't respond, the teacher made him turn out his pockets, take off his shoes, and then empty his desk. But the dime was not found anywhere. Billy put the things back in the desk without saying a word. He put his arms on his desk and buried his face in them. Later, the dime was found by the pencil sharpener, where Billy's accuser had laid it.

What if there had been a counselor in the school to whom Billy could feel free to express his humiliation, shame, and anger? What could the counselor do to help the teacher and Billy without breaking confidentiality? How could he or she let the teacher know how Billy really felt?

If counselors are to honor ASCA's guidelines, then before counseling they must tell a child that they will not divulge specific things said by the child without his or her permission, but that they may share a sense of the child's feelings about a situation with a teacher or parent. The counselor might add: "Sometimes it helps other people if they understand how you feel. Your feelings are important, too."

Of course there are times when a counselor cannot ethically keep a child's disclosures confidential. According to the ASCA *Position Statements* (1983), confidentiality may be abridged if the child imparts information that suggests "there is a clear and present danger to the client and to other persons" (p. 6).

It may be difficult, especially with young children, to distinguish between fact and fantasy or between genuine intentions and half-formed wishes. Making such distinctions necessitates that the counselor use careful judgment and possess well-developed in-

terpretive skills. These qualities must supplement the requirements found in ethical guidelines if the counselor is to observe more than the bare framework for ethical conduct.

Ethical Dilemmas in School

Many of the ethical dilemmas a counselor confronts are associated with when and how to report child abuse, the use and reporting of test scores, and informal communications within the school community. Concern and caring for the student is not enough. Professional organization standards and public law, integrated with the counselor's beliefs concerning the welfare of the student and the family, are essential to the process of ethical resolution of the dilemmas counselors face in schools.

Child Abuse

Careful evaluation is especially important when the counselor encounters a suspected case of child abuse or neglect. Although laws regarding reports of child abuse differ from state to state, the principal in many schools has the actual responsibility of reporting suspected cases of abuse to the designated authorities. Because counselors are often asked to make the initial evaluation in these cases, related ethical issues need to be considered by all elementary and middle school counselors.

The ASCA *Position Statements* (1983) provide several criteria for deciding whether child abuse may have occurred, and they suggest that the counselor use more than one of the criteria in making a decision. Only some of the criteria, however, have obvious implications for child abuse, such as patterns of bruises caused by a particular instrument (e.g., a belt buckle or coat hanger). Other criteria are more difficult to interpret, such as lacerations and abrasions. The counselor should be extremely careful in reporting suspected child abuse on the basis of limited and uncertain evidence. The involvement of at least two parties in the situation (such as the counselor and the principal) is helpful. Individual schools need clearly written guidelines for handling such cases.

Reporting of Test Scores and Other Information

Another area that requires deliberate and careful judgment is deciding the appropriate use and reporting of test scores. The

counselor may have to decide whether to use test scores in a consultation. In certain cases the counselor has no choice. The Educational Amendments of the Elementary and Secondary Education Act of 1965 (1974) state unequivocally that no federal funds will be made available to schools that deny parents "the right to inspect and review any and all official records, files and data directly related to their children" (p. 3). Such data specifically include "scores on standardized intelligence, aptitude, and psychological tests, interest inventory results, [and] teacher or counselor ratings and observations" (p. 3).

Many counselors are aware that parents have a legal right to obtain test scores but do not realize that a counselor's ratings and observations are also legally open to parental inspection. The provisions of the amendments immediately made obsolete an ethical standard issued by APGA in 1974 (the same year as the amendments): "The examinee's welfare and explicit prior understanding should be the criteria for determining the recipients of the test results" (p. 6). Law supersedes ethical standards, and confidentiality of test scores is no longer protected as it was before 1974. The problem of whether to give parents test scores with or without interpretation has generally been left to individual schools. The AACD *Ethical Standards* state: "The member must see that adequate interpretation accompanies any release of individual or group test data" (APGA, 1981, p. 3).

At this point, a counselor might say, "The law has begun to make *confidentiality* a hollow word." Legally a parent can obtain not only a child's scores on aptitude and achievement tests but also the results of personality inventories and the data a counselor has obtained from observations. In view of the broader ethical questions involved, it seems irrelevant that most parents are not going to ask for such information.

What can counselors do if they do not believe it is in the best interest of the client for parents to obtain this information? Perhaps counselors should avoid recording certain sensitive materials that may be open for inspection. In addition, taping counseling sessions may be unwise unless tapes are immediately listened to and erased. The ASCA *Position Statements* (1983) warn counselors to be especially careful with recorded information. In the past, clear distinctions were made in ethical standards between official school records and the counselor's personal records, which included scores on personality inventories and the counselor's notes on sessions with a client. Unfortunately, the 1974 amendments blurred this distinction, and there is still no adequate legal interpretation of

the phrase "data directly related to their children" (p. 452). The words could be interpreted as almost any data obtained in school. The words "any and all," which directly precede "official records, files and data," should immediately signal greater caution by the counselor. A counselor may be wise to keep two "Beware" signs posted in his or her mind. These signs would read: "Beware of Tape Recorders" and "Beware of Computer Data Banks." Unfortunately, the blessings of modern technology are hardly blessings for the counselor confronting ethical concerns.

Of course, the constraints of confidentiality apply only if a parent requests information. Perhaps the most difficult dilemmas arise when a parent calls a counselor and says, "My child tells me you gave him a test in which there were questions about whether he still wets the bed and whether the sight of blood makes him sick. What did you ask him those kinds of questions for?" The counselor can explain that he or she wanted to learn more about the child's perception of the world around him. Then the parent may ask, "Did the test show he was crazy or something?" The counselor can state that this inventory was not designed to determine whether people are crazy and that it really cannot be interpreted properly without further observation of the child. The counselor can add, "I honestly cannot say much about Johnny on the basis of this test score." Such an answer may satisfy the parent.

Laws, standards, and position statements all have bearing on consultations in which a teacher or parent does not directly ask for test scores. According to the ASCA *Position Statements*, unless a child has previously given the counselor permission, a counselor cannot discuss test scores even if the scores are relevant to the discussion or support what the counselor wants to communicate. If the child has given permission and test scores are presented, any discussion of the test scores should include an adequate interpretation of their meaning by the counselor.

When giving and interpreting tests, the counselor should select tests with norm groups that are representative of the child's socioeconomic, racial, and ethnic background. If the norm groups do not include appropriate representation, however, an explanation should be included in the interpretation.

It seems that test scores are becoming synonymous with education itself; therefore, it is more important for the counselor to stress that test scores are tentative assessments and are not, like the Ten Commandments, chiseled in stone. Indeed, ASCA in its *Position Statements* (1983) expressed opposition to "continued use

of standardized group intelligence tests . . . until a time when the problems with the tests and their users can be corrected" (p. 8).

Informal Communications

Much of the discussion about formal consultation also applies to the ethical dilemmas associated with more informal communication in a school. Each school is a small social organization, a little community, and as such has a web (sometimes a tangle) of social interrelationships. These relationships, if they are to be productive, require a set of ethical assumptions that help regulate how individuals attempt to live together.

An important aspect of day-to-day contacts involves the counselor's relationship to the leader of the small society, the principal. Of course, according to AACD guidelines, the principal should be informed if the counselor receives information from a client that indicates possible harm or injury to the child or others (APGA, 1981). But what if the principal asks for information that the counselor believes is protected and confidential? What if the principal flatly demands such information? There are certainly principals who are demanding and insistent. What if the child has told the counselor that he or she has taken several things from other students in the past and has lied about this, and the counselor is working with the student on these problems? The principal says, "Mrs. Burns thinks he's been stealing. She asked you to talk to Jerry about that. Has he been stealing? What did he tell you?"

The counselor knows the principal is a harsh disciplinarian who attaches labels to a child that will stigmatize the child for the rest of his or her life. What does the counselor answer?

The counselor should have explained to the school staff the function of an elementary school counselor and the implications of confidentiality and privileged communication. The counselor should also have made clear why confidentiality is essential to a helping relationship. A short workshop session with the entire school staff (including secretaries and custodians) might be an effective way for a counselor to clearly communicate these ideas. Perhaps the principal in our example had not understood the concepts. In this kind of situation it may not be wise for the counselor to say, "I cannot tell you what Jerry said. This would be a breach of confidentiality." Such a statement might only increase the principal's determination and hostility. It might be better to say, "Jerry and I have been

working through his problems together. I see some real progress." Or the counselor could say: "I believe Jerry has been responding to counseling sessions. We are beginning to develop a good relationship. His teacher has told me he has been getting along better with other students."

In responding to a demanding principal, the counselor should always keep two things in mind: "My basic obligation is to the welfare of the child" and "I am less likely to help a child if basic trust is broken." If Jerry were to be severely punished as a result of what the counselor said to the principal, what credibility would the counselor have in that school's community? There is also the question of the counselor's personal integrity. That may seem an old-fashioned word in an age of shifting values and deep uncertainties, but a counselor is lost without it.

Of course, not all principals are like the one we have described, but all principals and all school personnel will benefit if a school has its own set of written policies prepared by those who will be implementing these policies. The policies should, of course, be compatible with national and state laws, the ethical standards of professional associations, and the school district guidelines. (See the article by Walker and Larrabee in this issue of the journal for information on written policy making.) They should deal with such matters as child abuse, substance abuse, and the release of information.

Written policies and written requests are essential. In certain situations, of course, much of the communication in an elementary school is oral communication. There are casual contacts in the hallway, in the teachers' lounge, and in the teachers' lunchroom, and often the counselor is involved in these informal interchanges. Inevitably, a favorite topic in these situations is students, their peculiarities, and their behavior. After a rough morning in the classroom and on the playground, a frustrated teacher may make some pointed comments that help relieve his or her tensions but can also initiate equally pointed comments from other sources. The counselor must avoid being drawn into discussions in which confidential information about a student could slip out. Information tends to spread as quickly in a school as it would if it were flashed to a communications satellite. Unfortunately, some of that information could be legally classified as slander.

In one such situation several teachers were talking in a teachers' lounge. This conversation, which could have provided the basis for a law suit, followed: "Mildred was sent home at 9:30 this morn-

ing," one of the teachers said knowingly, "Guess what? Sick at her stomach."

"You know that family," another teacher said, "All their girls got pregnant. Regular as clockwork." She shook her head. "Poor Mildred. She's only 13." Then she added brightly, "But she is big for her age."

Fortunately, the door of the teachers' lounge was closed, and no students overheard this discussion. It is also fortunate that few teachers are sued for slander. That afternoon the girl had an operation for acute appendicitis.

Of course, it is easy after a tiring day, when the weather has been bad and no one could go outside, to say things that represent only a temporary mood and not actual feelings. Often a counselor may have the most exhausting day of anyone in a school. At these times a counselor must be especially careful that what he or she says does not violate a student's right to confidentiality.

With oral communication, another "Beware" sign needs to be posted: "Beware of the Telephone." The ASCA *Statements* (1983) say flatly, "Counselors must not discuss matters over the telephone" (p. 6). For some, the telephone has become an added appendage to their bodies, but what is said over the telephone can be overheard and can easily be misinterpreted. A disembodied voice on the telephone lacks the facial expressions and gestures that reinforce and clarify the meaning of what is said.

Furnishing information to others from school records requires written permission from students' parents or guardians. The various reasons for using records and the stipulations for sharing the information about students typically are established by school district policy. Requests for records are responded to by the principal or other administrators, but, to comply with the law, counselors must be aware of the conditions under which information may be released, because some school records may be in their custody. In addition to school records, other client information the counselor may have could also be subject to court order; this varies from state to state. A counselor should consult a knowledgeable lawyer if he or she ever becomes involved in such situations. (See Walker and Larrabee's guidelines for school records and Remley's suggestions for interactions with laywers and legal concerns in this issue). In addition, knowledge of related legislation is essential if counselors are to uphold high ethical and professional standards. Of course, knowledge of ethical standards set by professional organizations and the interpretation of these standards is essential if

counselors involve others in the consultation process to help elementary and middle school students.

Counselors must also look within themselves and develop skills for making a reflective analysis of specific situations. The counselor should also develop a willingness to withhold judgment that is not based on a reasonable amount of evidence. Finally, and most significantly, the counselor who seeks ethical integrity must respect the child, the child's needs, the child's possibilities, and the child's best interests. As far as possible, these factors should be the basis of decision in ethical matters. When seen from this perspective, ethical guidelines are not just lists of "thou shalt nots." Instead, they point toward trust, confidence, and respect for one another.

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Adolescents' Rights of Access to Counseling

John R. Klenowski

This article focuses on hindrances and problems confronting the adolescent and counselor when adolescents have to surrender their right to accept or to refuse treatment.

At a time when children and adolescents are being identified as a target population to be served by mental health professionals (Ambrose, 1981), it is important to work toward alleviating hindrances that prevent minors from receiving effective and timely counseling services. In this article reference to the minor is confined to adolescents age 15 to 18.

In reviewing the historical efforts to attain treatment rights for minors, it is apparent that a consistent and major issue in granting adolescents the right to consent to counseling involves their competency to give such consent. The competency of minors to give consent continues to be an issue as evidenced by a 1979 Supreme Court ruling in *Parham v. J.L. and J.R.* (Schwitzgebel & Schwitzgebel, 1980). In this case the Supreme Court observed that most children, including adolescents, are not able to make sound judgments and that their parents can and must make such timely decisions. Comprehensive reviews of developmental research indicate that adolescents 15 years of age and above are as intellectually and psychologically capable in most situations to make competent decisions concerning consent to mental health counseling as most adults (Grisso & Vierling, 1978; Hayes, 1979; Melton, 1981a). Conversely, the ability of minors under 15 years of age to give consent is not as certain because of this age group's constantly changing developmental and dependency needs and questionable ability to distinguish among treatment alternatives (Hayes, 1979; Melton, 1981a). Consent is defined as an act of reason whereby an individual can sort out the advantages and disadvantages of alternatives in a rational manner in order to make competent decisions

about one's life (Slovenko, 1978). Such a definition raises the question of when is a child transformed into an adult? The law is not consistent from state to state nor from one area of functioning to another. In order for examples to be specific, the State of Ohio will be used as a reference in this article.

Rights of Adolescents to Treatment

The issue of consent to treatment by minors is a multidimensional problem. The parent or guardian can refuse to give consent when the minor wants counseling or the parent can initiate counseling when the minor does not want it. At most community mental health centers the minor is seldom the applicant (Stewart, 1976). Referral is usually made by parents, schools, doctors, or the courts. If the minor were to be the applicant, the minor would most likely be ineligible for service without parental consent. Most states do not recognize minors as being competent to contract for treatment services. Mature minors in most states do not have the freedom to select the service they believe reasonable to resolve identified problems or concerns. This point is emphasized in an Ohio Department of Mental Health intradepartmental communication (Panico, 1979):

> Whenever any person under the age of eighteen years voluntarily admits himself or arrives at the Center as an "emergency walk-in" desiring treatment because he believes himself to be mentally ill, the parents, guardian, or person having custody of the minor should be notified immediately for the purpose of giving consent in order that the Center may consult with or treat the minor. If the parents, guardian, or person having custody of the minor refuse to give consent the minor may be detained, unless he refuses, only until the parents, guardian, or custodian come to the Center to pick up the minor; however, no treatment or consultation shall be given to the minor during the interim.
>
> In the event that the Center is unable to contact a parent, guardian, or person having custody of a minor for purposes of receiving consent from them to consult or treat a minor under the foregoing circumstances, the Center shall not consult with or treat a minor unless it is a case of grave emergency where a medical staff person

> feels that some intervention is necessary to prevent serious consequences or death of the minor. These cases of "grave emergency" should only be considered by a medical staff person, and, if available, at least two medical persons should concur that it is necessary for some type of consultation or treatment to be administered in order to avoid serious consequences or death of the minor.

What effect does the inability to obtain services have on adolescents when they are hurting or concerned? What does denial or postponing of services because of lack of parental consent do in perpetuating the stigma of receiving mental health counseling when the adolescent can make other important decisions, but not one regarding counseling? For example, the adolescent can work, can make purchases, can drive an automobile, or can receive help for a drug problem or venereal disease. In addition, Ohio law recognizes that minor children may be considered emancipated prior to their 18th birthday by marriage or by living independently from their parents. Ohio law also views minors as having the capacity to select their own guardian at age 14 and to select their custodial parent at age 12 (Spohn, 1980). In spite of being able to make such important life decisions, adolescents still cannot apply for counseling on their own in Ohio and many other states. Virginia, a state which implemented a law in 1979 permitting minors to consent to mental health treatment, was the focus of a survey by Melton (1981b) to determine the effects of the law on community mental health clinics. One finding was that although the law does not have an age standard, the only minors who applied for mental health counseling without parental consent were adolescents and not younger children.

Rights of Adolescents to Refuse Treatment

Up to this point focus has been on the right to counseling. If a person has a right to counseling, they should have a corresponding right to refuse counseling. Once again, the adolescent is denied a right by the same law that considers persons under 18 to be incompetent (Everstine, Everstine, Heymann, True, Frey, Johnson, & Seiden, 1980). In many mental health settings the refusal by minors to accept treatment does little to keep them from physically attending counseling sessions. In referring to such situations, Glenn

(1980) uses the concept of informed forced consent. That is, the minor is informed of why he or she is being seen but is not given any choice about participation. It is no surprise that many adolescents initially respond to mental health services in "resistant" ways.

Let us assume that conceptually the best of situations exists where the adolescent assents to treatment and has parental consent. Such a situation is not an indication that there will not be any further hindrances to counseling based on consent. For example, to be in accordance with the law on informed consent, the parents should be informed of the type of treatment their child will receive and aspects of the treatment plan (Glenn, 1980; Nye, 1980). The person giving the consent has to know what they are consenting to, and what alternatives to the proposed counseling process exist. The consentor also needs to know the prognosis and anticipated outcomes. One of a possible number of dilemmas may be that the adolescent, although wanting treatment, may not want the parents to know about the treatment. In some situations, it could even be contraindicated for the parents to know (Melton, 1981a; Nye, 1980). If the therapist is saying "Your parents need to know you are coming in," it can affect the degree of trust the adolescent will be able to invest in the relationship. Such situations can create difficulty in the therapeutic process where trust and a guarantee of privacy are important ingredients. This is documented by studies such as that by Howard and Orlinsky (1978), who concluded that effective therapy is an interpersonal process marked by a number of characteristics, one of which is mutual respect and trust. Barrett-Lennard (1981) also identified a trusting professional relationship as one of the unifying components of the counseling process.

Case Illustrations

To assist in focusing on the various ways treatment can be delayed, denied, or adversely affected by the adolescents' inability to consent to treatment, several vignettes are presented. The vignettes are based on situations that occurred at one mental health setting over a period of several months. To facilitate a problem-solving approach, and to stimulate the reader to ponder how similar situations might be handled in one's own setting, methods of responding are not presented. The implications of each vignette will be dependent on the specific law of each state.

Case One

An adolescent was referred by the school. The person was living with an aunt and uncle. In the course of getting consent, it was determined that the relatives had never received legal custody. Two years ago, when the parents moved to another state, they agreed it would be acceptable for the adolescent to live with the aunt and uncle during the school year so that he could graduate from a particular high school. Because the relatives did not have legal custody, treatment had to be delayed until contact was made with the parents.

Case Two

A call was received from a teacher who wanted to refer an adolescent boy who approached the teacher about his home situation. He was concerned about the fighting between his mom and dad. Could a center staff person see him to help advise him on some actions he could take? He did not want his parents to know as he was concerned it might aggravate the problems at home if the parents knew he had contacted the mental health center.

Case Three

A 15-year-old girl came to the clinic for counseling. Mother gave consent and daughter assented. Both mother and daughter stated they did not want the girl's father to know she was receiving counseling because they were fearful of his reaction. After the adolescent's second session, her father called the clinic and wanted to know if his daughter was a client.

Case Four

A client who was engaged in weekly counseling brought in a 17-year old friend who was "upset" about difficulties in her love relationship with a married man. She wanted to apply for counseling but did not want her parents to know as "it would just kill them."

I think the aforementioned examples demonstrate the range of possibilities and implications for both the adolescent and the therapist. The examples emphasize potential drawbacks to the establishment of a trusting relationship between adolescent and therapist, especially when the therapist must say to the adolescent "You need to have your parents' permission before I can counsel with you."

Rights of Parents

When parents give consent for the treatment of their child, the therapist has to be aware of the parents' rights as well as the adolescent's rights. In some situations it is not always easy for the therapist to determine whether responsibility is to the parent or to the adolescent client. Although most colleagues with whom I have consulted indicate allegiance to their client, and are supported in this position by their professional code of ethics, legal precedence would indicate parental rights usually take precedence over the child's rights (Nye, 1980). The parents are the ones who contract for service and who are responsible for paying for the service. In a situation where the adolescent client may be involved in a constructive and relevant counseling relationship, the parents can withdraw consent because they personally do not like the changes their adolescent is making (Everstine et al., 1980). Does the therapist risk alienating the parents and thus deprive the adolescent of services? Does the therapist go along with the parents' wishes, which may be contrary to the minor's clinical needs, because the therapist believes it is better to have the minor in treatment than to have services completely withdrawn? To accede to the parents' wishes in the aforementioned situation would put the counselor in a position for malpractice charges (Nye, 1980). If the counselor were to offer alternative action plans to the minor that were not of the minor's own making, the counselor might be subject to charges of undue influence (Schwitzgebel et al., 1980). To continue to see the minor after consent had been withdrawn also could lead to charges of contributing to the delinquency of a minor (Henkener, 1981).

The referral of a minor does not always come from the parents. A Children Services Board may threaten to remove a child from the home if the parents do not get the minor into counseling. A school principal may threaten a child with expulsion if parents do

not obtain counseling for the child. The referring agency may request to be kept informed of the minor's progress, a practice that is not unusual in many states (Popiel, 1980). Under such circumstances the counselor is confronted with additional blocks to establishing a strong position of confidentiality and for creating a climate of sharing and trust. In certain situations the referral of an adolescent to a mental health facility may be court ordered. Confusion can occur because of the gray area between delinquency and emotional illness. Such adolescents may be referred to appease an upset community system or to serve the needs of some disgruntled parents rather than to meet the needs of the minor. Other minors may have their cases dropped by the court without receiving any consideration for mental health intervention (Melton, 1981a). A mental health therapist was recently confronted by a situation where a 17-year-old was sent for counseling by a court order. The adolescent did not want counseling. The therapist did not believe counseling for the adolescent was appropriate and concluded that it would be more appropriate for the parent to receive mental health services. The parent refused service. The court representative responded to the therapist by saying, "Isn't it true counseling can't hurt anyone? It's either the counseling or I'm going to throw him (adolescent) in jail." The issue of rights for the adolescent regarding mental health counseling becomes more complicated when certain behaviors are accepted for adults (father's refusal) but not for adolescents.

What Can Professionals Do?

It takes time for laws to change and so the issues around adolescents' rights to treatment are likely to continue for some time. There are, however, some ways of dealing with the issues and working toward change. One immediate way of starting is to become familiar with the juvenile laws of your state. Many therapists are unfamiliar with the juvenile laws that affect their work. Melton (1981b), in reporting the results of a survey involving mental health clinics in Virginia, found that approximately 40% of the clinics were unaware of a Virginia state law that permitted minors to consent to psychotherapy. If possible, arrange to have access to a lawyer. An attorney knowledgeable in juvenile and mental health laws can be a valuable and supportive resource. To prevent misunderstandings and to lessen pressure from parents, it can be help-

ful to structure the ground rules of treatment early. Learn how to mobilize and manipulate resources by knowing when agencies such as schools, child welfare agencies, and courts can be allies. Church organizations and groups such as the League of Women Voters can be good resources when it comes to supporting human services. Work at developing your relationships with court personnel. Find out what the legislature is doing, who is doing it, and who has political connections. Make yourself and your points known to your local state legislators. They usually do not have the staff available to them to be knowledgeable in all areas. If you have made yourself and your areas of expertise known, you will have opened the door for the legislator to contact you.

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Avoiding Ethical Violations: A Timeline Perspective for Individual Counseling

Mary E. DePauw

The author outlines a timeline perspective that helps counselors avoid ethical violations and organize the ethical mandates that contribute to effective practice. Ethical considerations are proposed during the initiation phase of counseling, as counseling develops, when a period of crisis arises, and at the termination phase.

In recent years increased attention has been given to ethical issues in counseling. Concerned professionals have (a) explored specific ethical dilemmas such as confidentiality (Denkowski & Denkowski, 1982), (b) addressed the assets and limitations of ethical standards (Talbutt, 1981), and (c) questioned the assumptions of ethical recommendations for psychotherapy (Widiger & Rorer, 1984). The goal of all ethical exploration is to assist professionals in addressing their primary responsibility "to respect the integrity and promote the welfare of the client(s)" (American Association for Counseling and Development [AACD], 1981, Section B.1). The AACD (formerly APGA) *Ethical Standards* (1981) directly challenge members "to stimulate greater concern . . . for their own professional functioning and for the conduct of fellow professionals" (AACD, 1981, Preamble).

Counselors interested in avoiding ethical violations and establishing procedures to address the many ethical mandates that contribute to effective practice need an organizing structure. The timeline perspective outlined in this article helps counselors identify the relevant ethical considerations that occur over the course of a counseling relationship. The timeline focuses attention on issues that occur (a) during the initiation phase of counseling, (b) as counseling develops, (c) when a period of crisis arises, and (d) at the termination point (see Table 1).

Table 1

TIMELINE ETHICAL CONSIDERATIONS

I. *Initiation Phase Issues*
- A. *Pre-counseling considerations*
  - 1. Advertising
  - 2. Avoiding misuse of institutional affiliations
  - 3. Financial arrangements
  - 4. Donated services
- B. *Service provision issues*
  - 1. Adequacy of counselor skills, experience, and training
  - 2. Better service option for the client
  - 3. Concurrent therapist involvement
  - 4. Conflicting dual relationship
- C. *Informed consent issues*
  - 1. Structures to educate regarding purposes, goals, and techniques
  - 2. Explanation of rules of procedure and limitations
  - 3. Supervision and consultation release concerns
  - 4. Experimental methods of treatment

II. *Ongoing Counseling Issues*
- A. Confidentiality
- B. Special issues of confidentiality with minors
- C. Consultation
- D. Record keeping

III. *Dangerousness and Crisis Concerns*
- A. Threat to self
- B. Threat to others
- C. Child abuse
- D. Gray areas

IV. *Termination Phase Considerations*
- A. Referral if unable to assist
- B. Professional evaluation

Examples are included to highlight specific ethical issues on the timeline. The *Ethical Standards Casebook, Third Edition* (Callis, Pope, & DePauw, 1982) was sponsored by AACD to provide positive and negative examples that illustrate each operative ele-

ment of the *Ethical Standards* (AACD, 1981). Interested professionals may refer to this work for further clarification and additional illustrative ethical incidents.

Initiation Phase Considerations

Precounseling Considerations

Most counseling agencies, counseling partnerships, and individual practitioners are involved in publicizing their availability and developing a clientele. Advertising must be done "in such a manner so as to accurately inform the public as to services, expertise, profession, and techniques of counseling in a professional manner" (AACD, 1981, Section F.2). Section F.2 also specifies what members may list in advertisements and stresses clarity and accuracy. A related ethical caveat is the misuse of one's institutional affiliation to recruit clients for one's private practice (AACD, 1981, Section F.6).

Another precounseling consideration involves fee structure and financial arrangements. Although this issue is not addressed in the AACD *Ethical Standards*, the "Ethical Principles of Psychologists" (American Psychological Association [APA], 1981a) specify "advance financial arrangements that safeguard the best interests of and are clearly understood by . . . clients" (p. 636). Psychologists are further charged with contributing "a portion of their services to work for which they receive little or no financial return" (p. 636).

Service Provision Questions

When approached by people seeking counseling services, counselors must answer the question, "Should I provide services?" Section G.1 of the AACD *Ethical Standards* (1981) states that "members must define and describe the parameters and levels of their professional competency." During initial client contacts it is imperative not only to assess clients' needs but to determine the adequacy of counselor skills, experience, and training to provide the services requested or required by the client.

A related consideration is the availability of a better service option for the client. Hare-Mustin, Marecek, Kaplan, & Liss-Levinson (1979) explored examples of alternative helping systems as a

safeguard to assure that therapists enact their responsibilities to facilitate client informed choice. In Section F.1 (AACD, 1981) members are urged "to assist the profession by facilitating the availability of counseling services in private as well as public settings."

In determining the appropriateness of establishing a counseling relationship, two additional ethical aspects need consideration—a concurrently established counseling relationship and dual relationships. If the client is already involved in another counseling relationship, then either the client must choose to terminate that relationship or the counselor must obtain consent to contact the other professional to negotiate approval for concurrent counseling (AACD, 1981, Section B.3). Dual relationships with a client may take the form of personal relationships that may "impair . . . objectivity and professional judgment" or a professional relationship of an "administrative, supervisory and/or evaluative nature" (AACD, 1981, Section B.11). Dual relationship difficulties are not confined to the initiation phase and may arise at other stages of the counseling relationship.

Informed Consent Issues

When the counselor determines that it is appropriate to initiate a counseling relationship, a relevant question that must be addressed is, "What does the client need to know?" Section B.7 (AACD, 1981) indicates that "the member must inform the client of the purposes, goals, techniques, rules of procedure and limitations that may affect the relationship at or before the time that the counseling relationship is entered." Widiger and Rorer (1984) explored questions of incompatibility between ethical requisites of informed consent and certain therapeutic orientations and techniques.

Counselors need to determine structures appropriate to the setting of the practice for educating clients regarding basic information: the general counseling approach being proposed, specific techniques to be included, the professional qualifications and orientation of the therapist, and specific goals for the client in the counseling relationship. Gill (1982) discussed professional disclosure statements as they relate to consumer protection in counseling. Many counselors use a general description that appears on the request for services form and then is reviewed and expanded on during discussion with the client. An invitation to raise questions

or concerns about any aspect of the counseling process or relationship at any time is an appropriate addition to such a discussion.

An important aspect of informed consent procedures may involve engaging the client in a mutual decision-making process that encourages openness and establishes honesty between client and counselor. Realistic expectations for counseling can be established and any misconceptions clarified. The counselor can also discuss possible effects—positive and negative—that the client may not have considered.

Once consensus is reached with the client regarding the goals and direction of counseling, rules of procedures and limitations need to be clearly explained. Examples of issues in this category are cost factors, maintenance of case records, limits of confidentiality, scheduling, and length and duration of sessions.

A recent action by the APA Committee on Scientific and Professional Ethics and Conduct (APA, 1984) advises psychologists to "inform their clients at the beginning of a professional relationship if they intend to share information about their case with a supervisor or consultant" and to indicate "the nature of the information that will be disclosed" (p. 36). In discussing supervision and consultation release issues with clients, counselors who focus on the intent to use these relationships to develop an effective counseling process may not only minimize resistance but may educate clients to the overall profession's commitment to service.

Section B.12 (AACD, 1981) emphasizes that "all experimental methods of treatment must be clearly indicated to prospective recipients and safety precautions are to be adhered to by the member." Two definitions of *experimental* need to be considered (Callis et al., 1982): (a) "those treatments that at the time of use are essentially nonstandard practice in the profession, the efficacy of which are not proven either by research or by usual practice by members of the profession" and (b) "those treatments which at the time of use for a specific condition by any given member are novel in his or her repertoire of treatments for that given condition" (p. 48). An example of methods that could fall into the experimental category is group or individual counseling experiences for students with eating disorders. The critical factor in approaching such situations is "the honesty on the part of the practitioners about limitations of the state of the professional knowledge and/or their own professional experiences in the area of services which they are negotiating and undertaking to provide" (Callis et al., 1982, p. 49).

Although not an ethical mandate, developing written contracts with clients may be an effective practice. Hare-Mustin et al. (1979)

and Widiger and Rorer (1984) have discussed issues concerning contracts.

Ongoing Counseling Issues

Confidentiality

Section B.2 (AACD, 1981) indicates that the "counseling relationship and information resulting therefrom be kept confidential, consistent with the obligations of the member as a professional person." Denkowski and Denkowski (1982) concluded that the "professional requirement for safeguarding confidentiality seems to be purely ethical" (p. 373) and that "the extent of confidentiality that can be assured under . . . legal limitations is not absolute and is declining" (p. 374). Counselors need to attend to their professional role definitions, be knowledgeable of applicable state laws, and formulate practice procedures proactively. They also need to develop policies and procedures relative to confidentiality responsibilities that extend to supervision of support staff in counseling settings.

Protection of counseling records in educational settings is the intent of Section B.5 (AACD, 1981). Procedures for disclosure of information must be determined in accordance with the Family Educational and Privacy Rights of 1976. Other relevant state statutes or regulations should be identified and implemented.

A special case involves the treatment of minors with alcohol or drug abuse problems. Maintaining confidentiality of information disclosed about these problems is subject to state statute and may not be possible, without parental involvement, subsequent to the first interview (as mandated in Confidentiality of Alcohol and Drug Patient Records, 1973).

Consultation

Section B.9 (AACD, 1981) indicates that a "member may choose to consult with any other professionally competent person about a client" but must avoid placing the consultant "in a conflict of interest situation." The informed consent procedures described above permit counselors to discuss clients with other professionals when they are unclear about case progress or need additional information to work effectively with clients.

Record Keeping

"Records of the counseling relationship, including interview notes, test data, correspondence, tape recordings, and other documents, are to be considered professional information for use in counseling" (AACD, 1981, Section B.5). The APA "Specialty Guidelines for the Delivery of Services by Counseling Psychologists" (1981b) specify that records should "include, but are not limited to, identifying data, dates of services, types of services, significant actions taken, and outcome at termination" (p. 21). These guidelines also outline that (a) records be completed within a reasonable time, (b) records be retained for the length of time specified, (c) a system be established to protect confidentiality, and (d) special safeguards be used when electronic data systems are involved.

Release of information contained in counseling records "must occur only upon the expressed consent of the client" (AACD, 1981, Section B.5). Counselors need to be aware that many states have enacted statutes specifying the precise nature of release forms for clients of health services providers, including mental health practitioners.

Ethical Considerations Involving Danger

Threat to Self

Section B.4 (AACD, 1981) mandates that counselors act to protect the safety of any client whose condition indicates that there is clear and imminent danger to the client or others by taking reasonable action or by informing responsible authorities. Counselors need to pursue carefully any client suicidal ideation and make a judgment regarding dangerousness. Counselors should be knowledgeable of state statutes and relevant local procedures, including voluntary hospitalization options. Openly discussing counselor concerns and engaging the client in a decision-making process frequently results in client cooperation and voluntary hospitalization, thus avoiding involuntary procedures. The "assumption of responsibility for the client(s) behavior must be taken only after careful deliberation. The client must be involved in the resumption of responsibility as quickly as possible" (AACD, 1981, Section B.4).

Threat to Others

Section B.4 (AACD, 1981) also obligates counselors to pursue threats to others reported by clients. *Tarasoff v. Regents of University of California* (1976) has been interpreted to imply "a duty to warn" the endangered party based on a California statute. It is important for practitioners to know what is permitted or obligated based on local statutes. Denkowski and Denkowski (1982) suggested that counselors "formulate contingency plans for dealing with dangerous clients that are derived in consultation with an informed attorney, a local psychiatric hospital, and area law-enforcement personnel" (p. 374).

Child Abuse

Most states have legislated that actual or suspected child abuse be reported to designated authorities. Counselors should obtain the related specifics for their practice areas. Because of the recent reports of the prevalence of child sexual abuse, counselors who work with children may wish to develop procedures to obtain a comprehensive history to allow for disclosure of such problems.

Gray Areas

An ethical dilemma is raised for practitioners when clients report behaviors that, although not currently endangering, may become so (e.g., failure by a diabetic client to follow a prescribed medical regimen). Extension of the intent of current ethical standards would suggest the need for establishing procedures to enhance client problem resolution before a crisis occurs. For example, clients with eating disorders should be referred to a physician for examination, health education, and follow-up regarding the damaging effects of starvation and repeated purging. Establishing a continuing consultation relationship with the client's physician and having the physician collaborate in outlining actions that might be taken if life threatening behavior develops would also be effective practice strategies.

Termination Phase Considerations

Referral If Unable To Assist

Sections B.10 and F.4 (AACD, 1981) clearly indicate that when practitioners determine that the counseling relationship is no longer productive or that they are unable to assist the client, the relationship must be terminated immediately. Practitioners have an obligation to be knowledgeable of referral sources and to suggest appropriate alternatives. If the client declines the suggested referral, the practitioner is not obligated to continue the relationship.

Professional Evaluation

Section G.5 (AACD, 1981) mandates that "members must submit regularly to professional review and evaluation." The APA "Specialty Guidelines for the Delivery of Services by Counseling Psychologists" (1981b) specify that there "be periodic, systematic, and effective evaluations of counseling psychological services" to assess effectiveness, efficiency, continuity, availability, accessibility, and adequacy (p. 23). The acquisition of client follow-up data from each user of a practitioner's service not only provides evaluative feedback but enables that practitioner to establish a mechanism through which clients can express post-termination concerns.

Conclusion

The counseling profession does not lend itself to "cookbook" practices. The timeline perspective proposed here facilitates practitioner exploration of effective daily practices and procedures to avoid ethical violations. It also offers a valuable structure for teaching ethics to counselors in training and serves as a basic guideline for new practitioners.

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When a Colleague Practices Unethically: Guidelines for Intervention

James L. Levenson

When professionals learn of unethical professional practice by a colleague, they have an ethical obligation to intervene through appropriate evaluation and reporting. Sexual activity between a professional and a client is used as an example, and guidelines are provided for initial approach and evaluation, confidentiality, and the rationale for and ways of reporting misconduct. Ambivalence and resistance by both client and professional may interfere with needed intervention and must be worked through.

> *Dilemma.* Ms. B., a 30-year-old single woman, comes to Dr. Jones asking for counseling. She says that she has had chronic fears of getting close to men and has been too anxious to ever date. She had consulted Dr. Smith for the same problem 1 year previously. She began seeing him for regular sessions. She reports that Dr. Smith told her that she would learn to trust other men by learning to trust him. This initially involved embracing each other and progressed to sexual intercourse, which Ms. B. says continued for several months. Ms. B. became increasingly uncomfortable about her sessions with Dr. Smith and recently discontinued seeing him. What should Dr. Jones do?
>
> The many possible permutations of negligent behavior by a psychotherapist constitute an obsessive's nightmare and a scholar's delight. (Gutheil & Appelbaum, 1982, p. 152)

The ethical principles that guide professionals and the ethical dilemmas that they face have received much attention in recent

years. When a professional becomes aware of unethical conduct practiced by a colleague, however, there is little literature to consult on how to respond and intervene. Similarly, the impaired professional has become a topic of wide interest. There are many evaluation procedures and treatment programs for professionals who suffer from alcoholism or severe depression, but what of those who suffer from corruption?

Unethical behavior may include violation of confidentiality, negligent practice, sexual activity with a client, certain conflicts of interest, and questionable financial arrangements. Different professional groups have defined ethical guidelines that vary in specificity and mandate. Channels and procedures for processing complaints of unethical behavior may vary not only between professions but also within a particular profession from state to state. The purpose of this article is to describe the options for response when one learns of possible improper actions by a colleague. I focus here on professional sexual misconduct as an example and look at what Dr. Jones should do about Dr. Smith and Ms. B. I write from the vantage point of a psychiatrist, but the principles can be extrapolated to the wider group of mental health and counseling professionals.

Sexual activity between a professional and a client is explicitly considered unethical by the American Psychiatric Association (1984), the American Psychological Association (1981), and the National Association of Social Workers (1980). The American Association for Counseling and Development (AACD, formerly American Personnel and Guidance Association) (1981) cited sexual intimacy with a client as an example of a conflicting dual relationship that must be avoided. Although the Hippocratic oath (cited in Beauchamp & Walters, 1982, p. 121) forbids sexual relations between physician and patient, the American Medical Association's *Principles of Medical Ethics* (1980) and the recent American College of Physicians' "Ethics Manual" (1984) have not directly addressed the issue.

Learning of Misconduct

Learning from the Client: Assessing the Validity of Allegations

How one learns of possible professional misconduct affects the information's credibility and the potential for intervention. One may hear from the client directly as in the case of Ms. B. The

professional must first consider whether the client is capable of gross distortion of reality (i.e., that the allegations seem prima facie untrue). Such distortions may derive from an unsuccessful attempt to seduce the counselor, primitive rage and consequent retaliation after a perceived injury or slight, or underlying psychosis in which the client delusionally misinterprets the real relationship.

How can one tell if the client is telling the truth? If Ms. B. is disturbed enough to be lying or delusional about Dr. Smith, then Dr. Jones is almost certain to see gross interpersonal pathology in Ms. B's relationship with him. This may be the same or a different kind of distortion, such as paranoid suspiciousness or extreme idealization involving Dr. Jones or other people in Ms. B.'s life. Such serious pathology in relationships should lead to careful and critical examination of the allegations of sexual abuse but not necessarily to discounting them. After all, such clients are not immune to being taken advantage of by others, and they may be especially vulnerable to an unscrupulous authority figure.

Learning from Colleagues

One may also hear stories about a colleague's misbehavior from other colleagues. Such stories are hearsay evidence, ranging from convincing detail to shadowy rumor. In this case, a professional's prime responsibility is to strongly encourage any professional who has more direct knowledge of the misconduct to report it appropriately as described below. If one knows the accused professional personally, it may even be appropriate to discuss rumors directly with him or her.

Learning Directly From the Errant Professional

More directly, one may observe evidence of a colleague's misconduct, or he or she may confess. If this occurs in a setting in which the impaired colleague is himself or herself a client, confidentiality comes into conflict with the responsibility to intervene against unethical behavior. Many counselors and therapists would feel bound by confidentiality to not "turn in" a client who had confessed to professional misconduct. Confidentiality, however, is not an absolute good outweighing all other principles. If the misconduct poses a very serious threat to others, one must consider competing responsibilities and sometimes break confidentiality. Sexual abuse of child clients is such an example because of the

legislation that exists in all 50 states regarding mandatory reporting of child abuse.

Intervention

Consent, Confidentiality, and Clients' Reluctance to Report

Having learned from Ms. B. of Dr. Smith's misconduct and believing that her story is not manifestly false, Dr. Jones must obtain her written consent before taking any other steps. To proceed without her consent is not only a breach of confidentiality but an additional violation of her already injured integrity. Like a victim of rape or incest, the client who has been sexually abused by a trusted professional is likely to be deeply ambivalent about getting involved in reporting him or her for a number of different reasons. Ms. B. may be reluctant because of persistent affection for, dependence on, or fear of Dr. Smith. She may feel too guilty to report him, viewing herself as actively or passively complicit in forbidden behavior. She may fear that she will not be believed and that her own conduct and reputation will be maligned in the process (Burgess, 1981). She may wish to leave a traumatic experience behind as quickly as possible. It is therefore crucial that Dr. Jones carefully explore Ms. B.'s feelings and help her resolve conflicts over whether to proceed with reporting Dr. Smith. As part of this process, Dr. Jones should clearly identify sexual activity between counselor and client as professionally unethical and harmful to Ms. B.

In addition to clarifying the nature of the misconduct, exploring the client's ambivalence, and obtaining consent, the counselor needs to consider when the client is psychologically ready to pursue formal reporting. For most victims, readiness requires that they overcome guilt and self-blame sufficiently to understand that they really have been wronged. This entails awareness and expression of anger at having been victimized. A small number of clients, with more serious underlying psychopathology, may become psychotic, suicidal, or homicidal after having been sexually abused. They must be helped through treatment before the process of reporting and confrontation can be safely initiated.

Director Discussion with the Accused Professional

Given Ms. B.'s readiness and consent, Dr. Jones should first contact Dr. Smith to discuss the allegations directly. This step

complies with the AACD "Policy and Procedure for Processing Complaints of Ethical Violations." This gives Dr. Smith an early opportunity to take an active role in either defending himself or if he acknowledges the wrong, confronting and redressing it. In Minneapolis, Dr. Jones could consult the Walk-in Counseling Center, a model program that offers a service for processing complaints of sexual misconduct by therapists. Voluntary sessions would be held with Dr. Smith and Ms. B. both present (Schoener, 1984). Unfortunately, this option is not available in most locations.

Formal Reporting

After discussing the case with Dr. Smith, Dr. Jones should formally report the allegations if he still believes they may be true. Why? The number of professionals who engage in sexual acts with their clients is small, but of those who do, 75% to 80% engage in sexual acts with more than one client (Bouhoutsos, Holroyd, & Lerman, 1983). Clients frequently do not realize that sexual acts between client and counselor are unethical (Bouhoutsos et al., 1983). Reporting of professionals by professionals is necessary to protect a naive and vulnerable public from those few counselors who practice unethically.

Official reporting procedures vary among both professions and states. It is usually indicated but not always sufficient to notify the accused professional's supervisor, if there is one. If the professional is neither licensed nor a member of a professional society, then informing a supervisor is essential. Most professional organizations, including AACD, have ethics committees in most state or local branches, with formal procedures for investigating and ruling on possible misconduct. Dr. Jones should contact the appropriate representative of the committee. Usually, the state professional ethics committee can be reached through the association's president without the necessity of revealing any confidential information.

States license or certify professionals to varying degrees. If a licensing board exists, one must consider whether to file a report there as well. Such a report is indicated if Dr. Jones believes that Ms. B. is one of many clients that Dr. Smith has misused. On the other hand, if there remain doubts about Ms. B.'s allegations, it may be better to defer to the ethics committee's investigation and judgment. Legislation for mandatory reporting has been proposed for professional sexual misconduct but has been rarely adopted. There is a conflict here between competing ethical principles. On

the one hand, there is the responsibility to protect the public from unethical practitioners (beneficence and justice). On the other hand, there is the right of the individual client to determine whether he or she wishes to report the practitioner (autonomy). To supersede the right of autonomy would require the abridgement of confidentiality and consequently damage the client's trust. Therefore, legislatures have chosen not to make reporting mandatory when the client is an adult. Children, however, are not in a position to make fully autonomous choices. Sexual activity between a professional and a minor client constitutes child abuse and must be reported like any other form of child abuse.

If the offending professional received third-party payment for services (e.g., Blue Cross-Blue Shield, Medicare), an additional notification responsibility may be present. Some forms of misconduct, including engaging in sexual acts under the pretense of treatment, constitute fraud, and fradulent services should not be reimbursed (Sharfstein, 1985).

Professionals' Reluctance to Report

Given the wide consensus among mental health and counseling professionals that sexual activity between professional and client is unequivocally wrong, why are professionals reluctant to report? Historically, professionals have developed their identity and power partly through forging strong intraprofessional bonds predicated on common interests. Unfortunately, this has sometimes taken the form of an implicit expectation that no member of a professional organization will testify against another (Starr, 1982). If he reports Dr. Smith, Dr. Jones may fear that he will be ostracized by his colleagues as a traitor, becoming professionally isolated and losing referrals. Dr. Jones may be apprehensive that Dr. Smith will respond by suing him for libel, thereby causing Dr. Jones much expense and lost time in defending himself. Dr. Jones may believe that nothing much will happen to Dr. Smith as a result of reporting him and that it therefore is not worth the risks.

Carrying great responsibilities and being humanly fallible, many professionals cannot bring themselves to accuse another. Dr. Jones may believe that his own record is not without mistakes and be reluctant to come forward, thinking, "Who am I to condemn another's behavior?" Especially unfortunate, Dr. Jones may exhibit outright denial and refuse to believe that Ms. B.'s story could be true (Burgess, 1981). Alternatively, Dr. Jones may do nothing be-

cause he is not absolutely sure that Dr. Smith is guilty. If so, he fundamentally misunderstands his professional responsibilities. It is not Dr. Jones's role to be detective, judge, and jury. Ethics committees, licensing boards, and the legal process, not individual professionals, are charged with the responsibilities of determining guilt and punishing offenses. In any case, as compelling as one's responsibilities are, reporting a colleague is a very difficult and often lonely step.

Treating the Victim of Unethical Conduct

In addition to Dr. Jones's responsibility to report unethical professional conduct, he has the responsibility of treating Ms. B., the victim, or at least referring her for treatment. In some cases, it may be impossible for Dr. Jones to play both roles. Ms. B. may not believe that sessions with Dr. Jones can remain sufficiently private and confidential if he has reported Dr. Smith and perhaps will formally testify about the case. Stone (1983) has argued that it is preferable to separate what can be conflicting responsibilities and have one professional perform evaluation and intervention for reporting purposes and another treat the client without getting involved in any way in the reporting, thereby preserving confidentiality in the therapeutic relationship.

The specific methods and issues in providing psychotherapy to the victim of professional sexual misconduct are beyond the scope of this article. In referring such a client for therapy, however, the counselor should keep in mind that the client may resist treatment for any of the reasons outlined above. The counselor must also be sensitive to the varying appropriateness of individual, group, or marital therapy for each specific client.

Each practitioner must recognize his or her ethical obligations to clients, individual professions, and society and actively intervene when a colleague practices unethically. This task is not an easy one; it requires that professionals deal with ambivalence and resistance in both clients and themselves while simultaneously respecting clients' confidentiality and autonomy.

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Reporting Unethical Practices: Revised Guidelines

William Marchant

Professional counselors should interpret with caution Levenson's (January 1986) advice on reporting unethical practice by colleagues. The information is confusing and may be incorrect when reporting to a state licensing board or to the court system.

As an example, Levenson (p. 315) suggests that the counselor must assess the truthfulness of the client who makes an allegation against a colleague and contradicts the point (p. 317) by saying that it is not the counselor's role "to be detective, judge, and jury. Ethics committees, licensing boards, and the legal process, not individual professionals, are charged with the responsibilities of determining guilt and punishing offenses." He is correct on the second point. It is the responsibility of the various boards and committees to investigate a complaint and hold hearings on the allegations before determining guilt and punishment. That process relieves the counselor of the responsibility for determining the truthfulness of a complaint and leaves the counselor in place to continue therapy with the client, no matter what the outcome of the investigation.

Because a disciplinary hearing is adversarial, the burden in proving the case against the accused is held by the complaining party. The pressure is on the client to provide clear, specific testimony during the investigation and hearings. With that pressure, the client is likely to need support, rather than doubt, from the counselor.

Levenson suggests that treatment be concluded, or at least be well along the way, before the complaint can be made. In fact, it is important that the complaint be made as close to the occurrence as possible. Anyone who has been involved in counseling rape or abuse victims is aware of cases that have not been filed because too much time has passed between an event and the report of that

event. As a consequence, the counselor has had to deal with the anger of the victim toward the legal system, as well as toward the abuser, thus making the therapy more complicated and lengthy.

The counselor should treat the report or complaint as part of the therapy. Helping the client through the process of reporting an ethics violation and through the investigation and hearings is likely to help the client become stronger in dealing with feelings of vulnerability and, hence, in dealing with the world.

Levenson suggests that the counselor who is concerned with the ethical practices of a colleague should first discuss those concerns with that colleague (p. 316). Although such advice may be consistent with reporting ethical violations to AACD, it is incorrect when reporting to a state licensing board. Such a contact may interfere with a continuing investigation. Putting the offending therapist on guard may delay or otherwise interfere with the investigation.

The client may need information about the different kinds of complaints that may be filed. A criminal complaint should be filed with the local police or with the office of the district attorney. Such a complaint would allege a violation of criminal statutes, such as rape or sexual assault. An administrative complaint should be filed with the state licensing board. This complaint would allege a violation of statutes or regulations created by the board. The client may file a violation of ethical standards complaint with a professional organization. It is also possible to file a civil complaint against the therapist.

The purpose of listing these alternatives is to emphasize that the criminal complaint, the civil complaint, the complaint to the administrative board, and the report to the ethics committee are discrete reporting events. Making a complaint to one creates no guarantee that anything else will occur.

Levenson suggests that the therapist who reports an ethical violation may have difficulty in maintaining the therapeutic relationship because of loss of trust of the client through a violation of confidentiality. But if the therapist has obtained the consent and cooperation of the client in making the complaint, then confidentiality is no longer an ethical concern.

It would be best if the client makes the complaint, because no role confusion will exist. The counselor is free to be counselor and to provide support to the client during the process, which would avoid the confusion anticipated by Levenson of appointing one therapist to be the investigator and complainant and another therapist to be the counselor.

Ethical Concerns in School Counseling

Wayne C. Huey

In this article the author discusses ethical dilemmas inherent in the school setting that result from conflicts in counselor responsibilities to pupils, parents, and school. An ethical dilemma involving a pregnant student who is considering an abortion is described, and some possible counselor responses are discussed.

> *Dilemma.* Janice, a socially mature 16-year-old, confides in her counselor that she is pregnant. Her family is active in the "prolife" movement, and Janice held similar beliefs before the pregnancy. She now wishes to explore the physical and psychological ramifications of an abortion and seeks assurance that, whatever the final decision, the counselor will not reveal any information to her family. The counselor, who is also a strong "pro-lifer," contemplates informing the girl's parents.

The single characteristic that best distinguishes school counselors from other mental health professionals is a direct result of their work setting. School counselors work with minors and thus have certain legal and ethical responsibilities to parents as well as to clients. A potential conflict between allegiances to clients and parents is further compounded by ethical-legal responsibilities to the employing institution. In response to these and other issues in school counseling, the American School Counselor Association (ASCA) adopted the *Ethical Standards for School Counselors* (1984). These standards are not intended to replace the American Association for Counseling and Development (AACD, formerly American Personnel and Guidance Association) *Ethical Standards* (1981) but rather to complement them by clarifying the nature of ethical responsibilities of counselors in the school setting.

The purpose of this article is to provide a brief review of the school counselor's responsibilities to pupils, parents, and school.

An attempt is made to relate these three areas of ethical responsibilities to a specific dilemma, that of a pregnant teenage girl (Janice) considering an abortion, and to generate some realistic options for school counselors.

Responsibilities to Pupils

Duncan and Moffett (1974) cautioned that ethical standards do not give guidelines for every situation. The standards must be interpreted by each counselor in each context. Moreover, interpretation is a function of the counselor's personal values, beliefs, and attitudes. Counselors working with children need to be particularly careful not to promote acceptance of the counselor's values as the "right" ones. Section A.4 of the ASCA standards (1984) states that "The school counselor refrains from consciously encouraging the counselee's acceptance of values, lifestyles, plans, decisions, and beliefs that represent only the counselor's personal orientation." Clients of all ages have the right to choice and self-direction in their beliefs. Talbutt (1983) warned that it is not only unethical for counselors to impose their values and views on minors; it can result in legal action. The school counselor's role is to challenge and assist students to explore their own values on which they can base their own decisions. This task is not always easy. As individuals, counselors feel strongly about values, and such convictions are not readily pushed aside or effectively concealed. Attempting to deny a position or trying to ignore values may undermine the trust necessary for a productive counseling relationship. The school counselor should express his or her values and emphasize that they were accepted and incorporated after much thought and exploration. Although they seem right for the counselor, they are not accepted as right by all people. If a counselor feels so strongly about an issue that his or her effectiveness in the relationship will be impaired, a referral is appropriate.

Responsibilities to Parents

The counselor-client relationship is private and thus requires compliance with confidentiality standards; school counselors, however, work with minors, and their legal responsibility is generally to the parent, whereas their ethical responsibility may be more to

the client. Obviously, the legal and ethical requirements are not always in agreement, thus placing the counselor in a precarious position that must be balanced to ensure the rights of clients and at the same time ensure the rights of parents. Wagner (1981) reported that the younger the client, the greater the counselor's allegiance to the parent. She recommended, however, that children should have control over the release of information that results from their choosing to engage in the counseling process. Eberlein (1977) stated that most judges would be sympathetic to a client's request that a counselor not reveal information to the parent, and the counselor should not voluntarily inform parents of content unless the minor makes such a request.

For many school counselors, the issue is whether legal responsibility takes precedence over confidentiality based on professional ethics. Ethical codes do not supersede the law, and they should never be interpreted so as to encourage conduct that violates the law. Counselors must become familiar with local, state, and federal laws, but legal knowledge is not sufficient to determine the best course of action. Each case is unique, and laws are subject to interpretation; consequently, professional judgment will always play a role. Corey, Corey, and Callahan (1984) stated that although counselors need to use caution in legal issues, they must not become useless and paralyzed by meffectiveness. Counseling is risky, and counselors should not become so involved in legalism that they reduce client welfare to a secondary responsibility.

Responsibilities to the School

Section A.2 of the AACD *Ethical Standards* (1981) states that "The acceptance of employment in an institution implies that the member is in agreement with the general policies and principles of the institution. Therefore the professional activities of the member are also in accord with the objectives of the institution." Counselors should adhere to local school policies, whether determined by the principal or the board of education, to the extent possible without compromising their primary responsibility to the client. Counselors cannot afford to be perceived as more concerned about school rules than about student needs. When a conflict exists between a counselor's loyalty to the client and to the employer, the counselor should always attempt to find a resolution that protects the rights of the client; the ethical responsibility is to the client

first and the school second. Information obtained in the counseling relationship should remain confidential if the school's policies are not in the best interest of the client's well-being. When institutional policies exist that hinder the effectiveness of the counseling relationship, the counselor must actively use all available resources to promote a policy change in keeping with ethical standards of behavior.

Discussion

It is not uncommon for adolescents to seek advice about personal issues from school counselors, and a dilemma such as Janice's generates value-laden questions: What do you think about abortion? Should I have one? Where can I go? Will you help me? A counselor who views abortion as a viable alternative could help Janice clarify her choices and, if she wishes, suggest a referral to a family planning clinic. A counselor who accepts abortion provisionally could explore the situation with Janice to determine if referral to another counselor who can be more objective is warranted. If the counselor's values include viewing abortion as murder, then, based on ASCA standard A.9 ("The school counselor informs appropriate authorities when the counselee's condition indicates a clear and imminent danger to the counselee or others. . . ."), the counselor might feel justified in informing Janice that he or she must break confidentiality to prevent the abortion even though the consequences to his or her reputation among students would probably be severe. Whatever the interpretation, the counselor must still consider legal and ethical responsibilities to Janice's parents.

Generally, the courts have ruled that minors have a legal right to obtain abortions without the consent of parents (Talbutt, 1983). Section B.1 of the ASCA standards, however, states that "The school counselor respects the inherent rights and responsibilities of parents for their children and endeavors to establish a cooperative relationship with parents to facilitate the maximum development of the counselee." The counselor in this case should strongly encourage Janice to discuss the issue with her parents. The final decision, however, must rest with Janice.

Regarding institutional responsibilities, the counselor should determine whether the school has a policy concerning adolescent pregnancy and, in particular, the issue of confidentiality. Typically,

a policy does not exist, at least not in written form. If, however, reports to the parents or school are required, the counselor needs to consider carefully the full implications of making such a report. Ethical standards should always apply, regardless of the situation, and the counselor's concern for Janice's well-being must be foremost in the counseling relationship.

Applying ethical standards to practical situations is difficult because it involves values and human judgment. In the school setting it is especially difficult because the clients are minors. Moreover, there exists an ethical-legal responsibility to the school. School counselors confronting ethical dilemmas are often unsure where their allegiances lie; nevertheless, they must learn to tolerate the inherent ambiguity in ethical dilemmas. As trained professionals, school counselors have the capacity to take responsibility for their own judgments. Consultation and other resources are readily available through professional associations such as ASCA and AACD.

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